

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A13 M
30M REV. 1968

| | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|------------------------------------|--|
| 07579 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07583 | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last <i>Kemp James Adams</i> | | | | | | 2a. DATE OF DEATH Month Day Year <i>5 10 68</i> | | 2b. HOUR <i>4:51</i> AM | | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>Dec. 26, 1905</i> | | 6. AGE (in years last birthday) <i>62</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Sussex Co. Del.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>farmer and plumber</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Dorchester</i> | | 13c. CITY OR TOWN <i>rural</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>none</i> | | |
| 14. FATHER'S NAME First Middle Last <i>Arthur A. Adams</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Gertrude White</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>220-32-9813</i> | | 17. INFORMANT Address <i>Melvin L. Adams Federalsburg, Md.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>19 Days</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-22</i> , 19 <i>68</i> , to <i>5-10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Stephen P. Carney</i> | | | | | DEGREE <i>M.D.</i> | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>5-13-68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i> | | | | | 22e. ADDRESS <i>Easton, Maryland</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 23b. DATE <i>5/13-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Federalsburg Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Harvey Williams - Federalsburg Md.</i> | | | | | 25a. REC'D BY REGISTRAR DATE <i>MAY 16 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

17583

RECEIVED OF BILLS

07570



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | |
|---|--|--|--|---|
| 1. DECEASED-NAME (Type or print) VIRGIL N. ANDERSON | | 2a. DATE OF DEATH Month 5 Day 12 Year 68 | | 2b. HOUR 9:30 M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 12-16-1900 | 6. AGE (In years lost birthday) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Kentucky | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH TALBOT Md. | |
| 10. CITY OR TOWN OF DEATH EASTON | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk | 12b. KIND OF BUSINESS OR INDUSTRY Retail drug ind. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY Talbot | 13c. CITY OR TOWN Poplar Oak | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER |
| 14. FATHER'S NAME First Lawrence L. Middle Anderson Last | | 15. MOTHER'S MAIDEN NAME First Annie Middle Wilson Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 216-18-0262 | 17. INFORMANT Lawrence L. Anderson (Jr.) Address 6 Mercer St. Pocomoke, N.J. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Streptococcus Viridans DUE TO, OR AS A CONSEQUENCE OF 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF 10 days (c) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF 5 yr. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Cholecystitis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/15/68 , 19 68 , to 12/12/68 , 19 68 , that (I) (we) last saw the deceased alive on 11/15/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE R. G. Gullerath, M.D. DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5/12/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 5/14/1968 | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | 23d. LOCATION (City or Town) (County) (State) Washington, D.C. | |
| 24. FUNERAL DIRECTOR Maurice A. Neumann-John ADDRESS Easton, Md. | | 25a. REC'D BY REGISTRAR DATE MAY 15 1968 | 25b. REGISTRAR'S SIGNATURE John Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|------------------------------|--|---|---|---------------------------------|--|-----------------|------------------------|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
| William | | NELSON | Bedsworth | Month 5 - Day 8 - Year 68 | | | 11:50 M | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | WHITE | | SEPT. 28, 1908 | | 59 YRS. | | MONTHS | DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | USA | | | | TALBOT | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Easton | | Memorial Hospital | | Truck Driver | | Poultry | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Md. | | Talbot | | Easton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RFD #2, Box 503 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| Sidney R. Bedsworth | | Lula -- Faulkner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | 212-03-0678 | | E. Frances Bedsworth, Easton, Md., RFD #2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Heart failure | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) Myocarditis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4222 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| E. C. H. Schmidt | | | | | | | | 9 May 68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| E. C. H. Schmidt | | Easton, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Cremation | | May 13, 1968 | | Silverbrook Crematory | | Wilmington, Delaware | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Frampton Funeral Home | | Federalburg, Md. | | DATE MAY 13 1968 | | J. Charles Judge | | | |

8250

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

5790 • J. Neurosci., July 26, 2006 • 26(30):5783–5790

912

1. *Staphylococcus aureus*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-5 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) DAISY M. BLAKE | | 2a. DATE OF DEATH Month 5 Day 20 Year 68 | | 2b. HOUR 6:30 P.M. | |
| 3. SEX FEMALE | | 4. RACE Col. | | 5. DATE OF BIRTH Feb 9, 1904 | |
| 6. AGE (In years last birthday) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH TALBOT | | Md. | | | |
| 10. CITY OR TOWN OF DEATH EASTON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTON MEM. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DOMESTIC | |
| 12b. KIND OF BUSINESS OR INDUSTRY MAID | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | 13b. COUNTY TALBOT | |
| 13c. CITY OR TOWN EASTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 11 West street | |
| 14. FATHER'S NAME James H. Wells | | 15. MOTHER'S MAIDEN NAME El. Tilghman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. 218-20-4196 | | 17. INFORMANT Walter E. Blake | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE (MYOCARDIAL) 4270 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC CONGESTIVE FAILURE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days 1 1/2 yrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4341 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William E. Salmeron MD | | 22c. DATE SIGNED 21 May '68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 24, 68 | | 23c. NAME OF CEMETERY OR CREMATORY Richer Cem | |
| 23d. LOCATION (City or Town) (County) (State) EASTON TA. MD | | | | | |
| 24. FUNERAL DIRECTOR George N. Dabriel | | 24a. REC'D BY REGISTRAR Charles Judge | | 24b. REGISTRAR'S SIGNATURE Charles Judge | |
| DATE MAY 27 1968 | | | | | |

44786

RECEIVED IN THE OFFICE OF THE SECRETARY OF THE ARMY

DEPARTMENT OF DEFENSE

01582

3

100-100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) W. HENRY WILLIAM | | | First Middle Last | | | 2a. DATE OF DEATH Month May Day 8 Year 1968 | | 2b. HOUR 4:20 A M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 8-16-88 80 | | 6. AGE (In years last birthday) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot | | | | |
| 10. CITY OR TOWN OF DEATH Easton, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York | | | 13b. COUNTY West Chester | | 13c. CITY OR TOWN Ossining | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 32 Bell Avenue | |
| 14. FATHER'S NAME William | | | First Middle Last Brashears | | | 15. MOTHER'S MAIDEN NAME Laura | | | First Middle Last Smith | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 082-10-5399 | | 17. INFORMANT (Wife) Mrs. Evelyn Brashears, Ossining, New York | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure & Heart Block 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 1967 , to May 8th 1968 , that (I) (we) last saw the deceased alive on May 4th 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE C. R. W. Bain MD | | | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED May 8th 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) Callum R.W. Bain, M.D. | | | | 22e. ADDRESS 210 East Dover Street, Easton, Maryland. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 10, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Sleepy Hollow Cemetery | | | 23d. LOCATION (City or Town) (County) (State) N. Tarrytown N. Y. | | | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | | | ADDRESS | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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1933

3 years

Head failure & heart block

Arteriosclerosis heart disease

May 1933

May 1933

2nd floor elevator, London

Colours R. L. L. L. L. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

075884
Item#5, Film G401 6/21/68km

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07588

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) | | First KIMBERLY | | Middle VERNISE | | Last BRIGGS | | 2a. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1968</u> | | 2b. HOUR <u>7:20</u> PM | |
| 3. SEX FEMALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH APRIL <u>28</u> 1968 | | 6. AGE (In years lost birthday) YRS. <u>4</u> | | IF UNDER 1 YEAR MONTHS <u>4</u> DAYS <u>4</u> | | IF UNDER 24 HRS. HOURS <u>4</u> MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot | | | | Md. | |
| 10. CITY OR TOWN OF DEATH Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Infant | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE Md. | | 13b. COUNTY Caroline | | 13c. CITY OR TOWN Federalsburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 306 Smith Street | | | |
| 14. FATHER'S NAME First Hervie | | Middle F. | | Last Malloy | | 15. MOTHER'S MAIDEN NAME First Beatrice | | Middle L. | | Last Briggs | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <u>NO</u> (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Beatrice Briggs, Federalsburg, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>7622</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MOTHER ECLAMPSIA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 hours</u> <u>3 days</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>7795</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>4-29</u> , 19 <u>68</u> , to <u>4-30</u> , 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>4-30</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Richard F. Tyson M.D.</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>5-3-68</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>RICHARD F. TYSON</u> | | 22e. ADDRESS <u>EASTON (21601) Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 10, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery | | 23d. LOCATION (City or Town) Federalsburg, Maryland | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR <u>from Transp. Co. Federalsburg, Maryland</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <u>MAY 13 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|---|---|--|---------------------------------------|---------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last ERNEST Ira ERIE Buckle | | | | | | 2a. DATE OF DEATH 5 Month 28 Day 68 Year | | | 2b. HOUR 1:45 PM | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH 2-21-92 | | 6. AGE (In years last birthday) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH TA/60t | | | Md. | | |
| 10. CITY OR TOWN OF DEATH Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland | | 13b. COUNTY Caroline | | 13c. CITY OR TOWN Ridgely | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER None | | | |
| 14. FATHER'S NAME First Middle Last Rubin Buckle | | | | 15. MOTHER'S MAIDEN NAME First Middle Last ? Cannon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 220-34-9223 | | 17. INFORMANT Address Pearl Buckle Ridgely, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lymphocytic Leukemia 2041 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2040 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from June , 19 67 , to Aug 28 , 19 68 , that (I) (we) last saw the deceased alive on 28 Aug 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Stephen P. Carney | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5-29-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Stephen P. Carney | | 22e. ADDRESS Easton, Maryland 21601 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5-31-68 | | 23c. NAME OF CEMETERY OR CREMATORY Greensboro | | 23d. LOCATION (City or Town) (County) (State) Greensboro Caroline, Md. | | | | | |
| 24. FUNERAL DIRECTOR J.E. Boulaire | | ADDRESS Greensboro, Md. | | 25a. REC'D BY REGISTRAR JUN 3 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|---------|------------------------------|--|--|------------------------------------|--|---|--|----|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Lost | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- MATED <input type="checkbox"/> | | Month Day Year | | 2b. HOUR |
| GOLDIE MEEKINS CARTER | | | | | | 5 30 1968 | | 8:15 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| F | W | Feb. 28, 1895 | 73 YRS. | MONTHS | DAYS | HOURS | MIN. | Month Day Year | 19 | M |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | USA | | | | TALBOT | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| EASTON | | | MEMORIAL HOSP. | | | housewife | | Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Ohio | | | | | | Columbus | | | | 3323 East 6th Avenue |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Lost | | | First Middle Lost | | | | | | | |
| Samuel E. Meekins | | | Alverta ? Seward | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | |
| No | | | unk | | | LeCompte Funeral Service records | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple contusions, lacerations, abrasions & fractures</u> 812.1 DUE TO, OR AS A CONSEQUENCE OF <u>abrasions & fractures</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8164 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | c 440 P.M. May 30 1968 | | | Pass in car in 2-car collision | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | highway #50 | | | Route 50 at Easton Talbot Md | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 31 May 1968 | | | | |
| Louis S. Welty MD | | | for DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | Jun 3, 1968 | | Greenlawn Cemetery | | Cambridge, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| LeCompte Funeral Service, Cambridge, Maryland | | | | | | JUN 3 1968 | | Charles Judge | | |

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Ohio

Samuel

Leop. Gie. funeral service records

Leop. Gie. funeral service records

Leop. Gie. funeral service records

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Charles H. Cole</i> | | | | | 2a. DATE OF DEATH Month <i>5</i> Day <i>14</i> Year <i>68</i> | | | 2b. HOUR <i>2:22</i> P.M. | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>9-12-76</i> | | 6. AGE (In years last birthday) <i>91</i> YRS. | | IF UNDER 1 YEAR MONTHS <i>91</i> DAYS <i>00</i> HOURS <i>00</i> MIN <i>00</i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Delaware</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>TALBOT</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Retired Farmer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i> | | 13b. COUNTY <i>Caroline</i> | | 13c. CITY OR TOWN <i>Ridgely</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>None</i> | |
| 14. FATHER'S NAME First <i>James</i> Middle <i>Cole</i> Last <i>Cole</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>?</i> Middle <i>Roach</i> Last <i>Roach</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>220-52-7911P</i> | | 17. INFORMANT Address <i>Mark Cole Ridgely, Maryland</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>485X Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senility</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Unknown</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>491X Senility</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>5</i> Day <i>14</i> Year <i>68</i> P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-10</i> , 19 <i>68</i> , to <i>5-14</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Robert W. Trever</i> | | | | | DEGREE <i>ATTENDING PHYS.</i> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>5-15-68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever, M.D.</i> | | | | | 22e. ADDRESS <i>Easton, Maryland</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, ETC. <i>REMOVED</i> | | 23b. DATE <i>5-16-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Ridgely</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Ridgely, Caroline, Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>John E. Boule's Funeral Home</i> | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <i>MAY 20 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

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VR 415 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|-----------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Lucinda A. Copper | | | | | | 2a. DATE OF DEATH Month 5 Day 17 Year 68 | | | 2b. HOUR 12:30 AM | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH 3/19/26 BH116468 | | 6. AGE (In years lost birthday) 42 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot Md. | | | | | |
| 10. CITY OR TOWN OF DEATH EASTON | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laundry Work | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN Easton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Easton Point Easton, Md. | | | |
| 14. FATHER'S NAME First Charles Middle Hawkins Last Rosie | | | | 15. MOTHER'S MAIDEN NAME First Rosie Middle Warrick Last Warrick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 213 16 8497 | | 17. INFORMANT Lewis Copper Easton Point Easton, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INSUFFICIENCY 180 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CA. OF CERVIX 16 M O | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 170 1 1/2 170 16 M O | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 171 X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE John Knud-Hansen, M.D. | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5-17-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS Easton, Md. 21601 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 5-20-68 | | 23c. NAME OF CEMETERY OR CREMATORY Newtown | | 23d. LOCATION (City or Town) (County) (State) Cordova Talbot Maryland | | | | | |
| 24. FUNERAL DIRECTOR B.E. Dashiell | | ADDRESS 426 DOVER EASTON, MD. | | 25a. REC'D BY REGISTRAR DATE MAY 24 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 1486 | 1487 | 1488 | 1489 | 1490 | 1491 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07589

07593

| | | | | | | | | | |
|--|--|---|--------|---|--|--|----------------------------|--|-----------------------------------|
| 1. DECEASED-NAME (Type or print) CHARA | | First M. | Middle | Last DobRASKi | 2a. DATE OF DEATH Month May Day 11 Year 1968 | | 2b. HOUR 11:48 M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Dec. 14, 1916 | | 6. AGE (In years last birthday) 51 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH TALBOT | | Md. | |
| 10. CITY OR TOWN OF DEATH Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) McMoriah | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Caroline | | 13c. CITY OR TOWN Greensboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER None | |
| 14. FATHER'S NAME First Frank Middle Schmitt | | | | 15. MOTHER'S MAIDEN NAME First Marie Middle Henschel | | | | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No | | 16b. SOCIAL SECURITY NO. 216-07-4542 | | 17. INFORMANT Address Emil Dobraski Greensboro, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancytopenia due to Butazolidin idiosyncrasy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2924 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-3 , 19 67 , to 5-11 , 19 68 , that (I) (we) last saw the deceased alive on 5-11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert W. Trever | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert W. Trever, M.D. | | | | 22e. ADDRESS Easton, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REBURY, ETC. Burial | | 23b. DATE 5-14-68 | | 23c. NAME OF CEMETERY OR CREMATORY Greensboro | | 23d. LOCATION (City or Town) (County) (State) Greensboro, Caroline, Md. | | | |
| 24. FUNERAL DIRECTOR J. E. Bouclair, Greensboro, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

1035 pm
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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. LENGTH OF STAY IN lb <u>EASTON</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL</u> | | e. STREET ADDRESS <u>23 Locust st.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>CHARLES N. EVANS</u> | | 4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1968</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>CH</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/24/22</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>John Cuff</u> | | 14. MOTHER'S MAIDEN NAME <u>Louise Evans</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-146641</u> | |
| 17. INFORMANT <u>Mrs Louise Morris</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3950</u> DUE TO <u>Congestive Failure</u> (b) <u>Aortic Stenosis & Insufficiency</u> DUE TO <u>Year</u> (c) <u>Rh. fever</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>None</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>411X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Leanne M. Mundy</u> | | 22. DATE SIGNED <u>6-3-68</u> | |
| EXAMINER'S NAME (Type) <u>WELTK</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>June 3 1968</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u> | 23d. LOCATION (City or Town) (County) (State) <u>EASTON TA MD</u> |
| 24. FUNERAL DIRECTOR <u>Leanne M. Mundy Easton MD</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUN 5 1968</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|---|---|---|--|---|--|-------------------------------------|-----|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last <u>Joseph Henry Gernert</u> | | | 2a. DATE OF DEATH Month Day Year <u>5 7 68</u> | | | 2b. HOUR <u>8:15</u> M | | | | | |
| 3. SEX <u>MALE</u> | | 4. RACE <u>WHITE</u> | | 5. DATE OF BIRTH <u>MAY 26-1914</u> | | 6. AGE (In years lost birthday) <u>53</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Talbot</u> | | | Md. | | |
| 10. CITY OR TOWN OF DEATH <u>EASTON</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>WATERMAN</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> | | 13b. COUNTY <u>QUEEN ANNE</u> | | 13c. CITY OR TOWN <u>GRASONVILLE</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>xx</u> | | | |
| 14. FATHER'S NAME First Middle Last <u>CHRISTIAN GERNERT</u> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <u>ALICE HIGDON</u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <u>No</u> | | | 16b. SOCIAL SECURITY NO. <u>214-03-2258</u> | | 17. INFORMANT Address <u>MARCELLA GERNERT-GRASONVILLE</u> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undifferentiated sarcoma</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1992</u> <u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-30</u> , 19 <u>68</u> , to <u>5-7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert W. Trever</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED <u>5-7-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u> | | | | | | | | | | 22e. ADDRESS <u>EASTON, MARYLAND</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>5-9-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL-WOODLAWN</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>EASTON MD.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>Home Funeral Home, Church Hill, Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>MAY 13 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

0250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 07592 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07596 | |
|---|---|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME (Type or print) <i>James Aubrey Goldborough</i> | | | 2a. DATE OF DEATH | | 2b. HOUR |
| | | | Month <i>5</i> Day <i>14</i> Year <i>68</i> | | M <i>5:35</i> |
| 3. SEX <i>male</i> | 4. RACE <i>Negro</i> | 5. DATE OF BIRTH <i>march 2 1914</i> | | 6. AGE (In years lost birthday) <i>54</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>md</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Allegria</i> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sanitor</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>School</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i> | 13b. COUNTY <i>Talbot</i> | 13c. CITY OR TOWN <i>Belleve</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER <i>Box 66</i> | |
| 14. FATHER'S NAME First <i>Aubrey</i> Middle <i>Goldborough</i> Last <i>Bessie M. Gummy</i> | 15. MOTHER'S MAIDEN NAME First <i>Bessie</i> Middle <i>M. Gummy</i> Last <i>Bessie M. Gummy</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. <i>217-03-4566</i> | 17. INFORMANT Address <i>Mrs Flora mae Goldborough - Belleve md</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> | | | | | <i>18 months</i> |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Diabetic glomerulonephritis</i> | | | | | <i>5 yrs</i> |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>260X</i> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>aug</i> , 19 <i>63</i> , to <i>5-11</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-11</i> , 19 <i>68</i> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Stephen P. Carney</i> | DEGREE <i>M.D.</i> | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED <i>5-13-68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i> | 22e. ADDRESS <i>Easton, Maryland</i> | | 22f. DATE SIGNED <i>5/13/68</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 23b. DATE <i>5/15/68</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Richard - Com</i> | 23d. LOCATION (City or Town) <i>Easton TA</i> (County) <i>md</i> (State) | | |
| 24. FUNERAL DIRECTOR <i>George H. Daskal</i> | ADDRESS <i>Easton md</i> | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |
| | | | DATE <i>MAY 16 1968</i> | | |

The first part of the report
 deals with the general
 situation of the
 country and the
 progress of the
 work during the
 year. It is
 followed by a
 detailed account
 of the various
 projects and
 the results
 obtained. The
 report concludes
 with a summary
 of the work
 done and a
 list of the
 references.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 07593 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07597 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Viola</i> | | | | | First <i>Sold</i> Middle <i>Stein</i> Last | | | | | 2a. DATE OF DEATH <i>5</i> Month <i>31</i> Day Year <i>68</i> | | | | | 2b. HOUR <i>6P</i> M | | | | | | | | | | | | | | |
| 3. SEX <i>Female</i> | | | | | 4. RACE <i>white</i> | | | | | 5. DATE OF BIRTH <i>Sept. 17, 1897</i> | | | | | 6. AGE (In years last birthday) <i>70</i> YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i> | | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i> | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i> STATE | | | | | 13b. COUNTY <i>Caroline</i> | | | | | 13c. CITY OR TOWN <i>Kidley</i> | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| 14. FATHER'S NAME First <i>Fred</i> Middle <i>allen</i> Last | | | | | 15. MOTHER'S MAIDEN NAME First <i>Ladie</i> Middle <i>McTihenney</i> Last | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | | | 16b. SOCIAL SECURITY NO. <i>121-10-8624D</i> | | | | | 17. INFORMANT <i>Mrs. Edna Mott</i> Address <i>Kidley Md.</i> | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>433.9 Cerebral thrombosis</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <i>Cerebral arteriosclerosis</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>332x Arteriosclerotic heart disease</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-26</i> , 19 <i>68</i> , to <i>5-31</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5-31</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Robert W. Trever</i> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED <i>6-1-68</i> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>ROBERT W. TREVER</i> | | | | | | | | | | | | | | | 22e. ADDRESS <i>RD 3 Easton, Md.</i> | | | | | | | | | | | | | | |
| 23a. BURIAL OR CREMATION REMOVAL <i>buried</i> | | | | | 23b. DATE <i>June 4, 1968</i> | | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Mem. Park</i> | | | | | 23d. LOCATION (City or Town) (County) (State) <i>Mt. Airy New Jersey</i> | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Maurice K. Newman-Saw</i> ADDRESS <i>Easton, Md.</i> | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE <i>JUN 4 1968</i> | | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | | |

MEDICAL CERTIFICATION

[Faint, mostly illegible text covering the main body of the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1514
30M REV 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) RALPH PALMER GREEN | | | | | 2a. DATE OF DEATH Month May Day 10 Year 1968 | | | 2b. HOUR 11:45 P. | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 3/15/1911 | | 6. AGE (in years last birthday) 57 YRS. | | IF UNDER 1 YEAR MONTHS 5 DAYS 10 HOURS 45 MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH TALBOT | | | | |
| 10. CITY OR TOWN OF DEATH Easton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAINTER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY TALBOT | | 13c. CITY OR TOWN EASTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 518 AUGUST ST. | |
| 14. FATHER'S NAME First WILLIAM F. Middle GREEN Last GREEN | | | | | 15. MOTHER'S MAIDEN NAME First JESSIE M. Middle MARSHALL Last MARSHALL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW II | | | 16b. SOCIAL SECURITY NO. 212-16-7395 | | 17. INFORMANT Address MRS. RALPH P. GREEN, EASTON, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185X Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Uterine obstruction DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 177X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 Feb. 1968 , to 10 May 1968 , that (I) (we) last saw the deceased alive on 10 May 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Edmund J. Fitzgerald DEGREE M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) Edmund J. Fitzgerald, M.D. | | | | | 22e. ADDRESS Easton, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 5/13/1968 | | 23c. NAME OF CEMETERY OR CREMATORY SPRING HILL | | 23d. LOCATION (City or Town) (County) (State) EASTON, MD | | | | |
| 24. FUNERAL DIRECTOR Marion E. Newman ADDRESS Easton, Md. | | | | | 25a. REC'D. BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |
| | | | | | DATE MAY 15 1968 | | | | | |

U. S. DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (M)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Lewis</i> | | | First <i>Herbert</i> Middle <i>Griffith</i> Last | | | 2a. DATE OF DEATH <i>5</i> Month <i>11</i> Day <i>68</i> | | 2b. HOUR <i>7:15</i> M | |
| 3. SEX <i>M</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH <i>OCTOBER 29, 1912</i> | | 6. AGE (In years last birthday) <i>55</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOUR MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Alumaria</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>PLANT NURSE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i> | | 13b. COUNTY <i>TALBOT</i> | | 13c. CITY OR TOWN <i>NEWCOMB</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME <i>LEWIS</i> | | | First <i>HERBERT</i> Middle <i>GRIFFITH, SR</i> Last | | | 15. MOTHER'S MAIDEN NAME First <i>JULIA</i> Middle <i>SUTTON</i> Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>YES</i> | | (If yes give war or dates of service) <i>WORLD WAR II</i> | | 16b. SOCIAL SECURITY NO. <i>531-26-3017</i> | | 17. INFORMANT Address <i>MRS. L. HERBERT GRIFFITH, JR. NEWCOMB, MD.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1469 Gastric Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cachexia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ca of Oral-pharynx</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>148X</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/11/68</i> , 19 <i>68</i> , to <i>5/11/68</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>5/11/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>William E. Latimer, M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED <i>12 May '68</i> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>William E. Latimer, M.D.</i> | | | | | 22e. ADDRESS <i>Easton, Md.</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>MAY 14, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL CEMETERY</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>EASTON TALBOT MD.</i> | | |
| 24. FUNERAL DIRECTOR <i>John J. ...</i> ADDRESS <i>Easton, Md.</i> | | | | | 25a. REC'D BY REGISTRAR DATE <i>MAY 16 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. ...</i> | | |

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem being studied. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

17-4-20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Sarah Catherine Grunden</i> | | | | | | 2a. DATE OF DEATH 5 Month 27 Day 1968 Year | | 2b. HOUR 4:15 M | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH 3/19/1890 | | 6. AGE (In years lost, birthday) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Pa.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>607 Hardin Street</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Talbot</i> | | 13c. CITY OR TOWN <i>Easton</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>607 Hardin Street</i> | |
| 14. FATHER'S NAME First Middle Last <i>Ephriam Wilson</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Ida C. Eckenrod</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>214-32-58710</i> | | 17. INFORMANT Address <i>Mrs. Doris Phillips, Easton, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusions</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4201</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/2</i> , 19 <i>67</i> , to <i>5/27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3/15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Robert M. McDonald</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>5/29/68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>Robert M. McDonald, MD</i> | | | | 22e. ADDRESS <i>2 S. Hanson Street, Easton, Md. 21601</i> | | | | | |
| 23a. BURIAL, CREMATION, or other disposition <i>Burial</i> | | 23b. DATE <i>5/30/1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>MURPHY E. NEUNAM & SON, Easton, Md.</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>MAY 31 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 07597 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07601 | | | | | |
|---|--|--|--|---|--|--|--|--------------------------|--|-------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| KENNETH | | E | | HARRISON JR. | | | | Month 5 Day 7 Year 68 | | 6p M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| MALE | | WHITE | | 6-13-12 | | 45 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| MARYLAND | | USA | | | | TALBOT Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| EASTON | | MEMORIAL | | TRUCK DRIVER | | OIL | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MARYLAND | | TALBOT | | ST. MICHAELS | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| KENNETH E. HARRISON, SR | | | | | | | | NORA WISE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| 118 | | | | 210-16-391 | | MRS. KENNETH E. HARRISON JR. | | ST. MICHAELS, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 1890 | | DUE TO, OR AS A CONSEQUENCE OF | | Carcinoma of Kidney | | 11 years | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 180X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. City or Town County State | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967, to May 1, 1968, that (I) (we) lost the deceased on May 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| R. Lane Wroth, M.D. | | | | | | | | 5-3-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| R. Lane Wroth, M.D. | | St. Michaels, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | 5/4/1968 | | ST. JOSEPH'S | | CORDOVA, MD | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Maurice E. Neumann, Sr. | | Easton, Md | | DATE MAY 7 1968 | | Charles Judge | | | | | |

Very respectfully,
Yours truly,
[Signature]

[Faint, illegible text follows, appearing to be a letter or report.]

Very truly yours,
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

| 07593 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07602 | | | |
|---|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) SEVILLA ^{First} JACKSON ^{Middle} HOSKINS ^{Last} | | | 2a. DATE OF DEATH Month <u>May</u> Day <u>32</u> Year <u>1968</u> | | | 2b. HOUR <u>11:45</u> M | | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH Nov. 30, 1886 | | 6. AGE (In years last birthday) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot Md. | | | |
| 10. CITY OR TOWN OF DEATH Essex | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Williamsburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER RFD | |
| 14. FATHER'S NAME First Middle Last Basil Jackson | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sarah Jackson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 213-16-7868 | | 17. INFORMANT Address Mrs. Gertrude Green, Preston, Maryland, RFD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Thrombosis - (R) hemiplegia</u> 433.9 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>332x</u> <u>Constrictive heart failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>16 May</u> , 19 <u>68</u> , to <u>22 May</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>22 May</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Thurston Harrison M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>22 May 68</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u> | | | | 22e. ADDRESS <u>Essex Maryland</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 27, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery | | 23d. LOCATION (City or Town) (County) (State) Denton, Maryland | | | |
| 24. FUNERAL DIRECTOR <u>Frank Tom Funeral Home Federalburg Md.</u> ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|---------------------------------|---|---|--|--|-------|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>Roy</u> <u>Hubbard</u> | | | | | | 2a. DATE OF DEATH <u>May</u> <u>11</u> <u>1968</u> | | | 2b. HOUR <u>3:30</u> <u>A</u> <u>M</u> | | |
| 3. SEX <u>M</u> | | 4. RACE <u>W</u> | | 5. DATE OF BIRTH <u>SEPT. 6, 1898</u> | | | 6. AGE (In years lost by death) <u>69</u> YRS. | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>TALBOT</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>EASTON</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>TEACHER</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u> | | | 13b. COUNTY <u>CAROLINE</u> | | 13c. CITY OR TOWN <u>DENTON</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME First <u>Silas W.</u> Middle <u>Hubbard</u> Last <u>Hubbard</u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Fortney</u> Last <u>Fortney</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MRS. ROY HUBBARD</u> Address <u>DENTON MD</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> <u>395.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Calypso aorta stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u> <u>many years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4211</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>may</u> , 19 <u>65</u> , to <u>11 may</u> , 19 <u>68</u> , that (I) (<input checked="" type="checkbox"/>) last saw the deceased alive on <u>10 may</u> 19 <u>68</u> , and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/>) (<input type="checkbox"/>) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Stephen O. Cunningham</u> DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>5-11-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>MAY 15, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>FOUNT</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BARBOURSVILLE KENTUCKY</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>CHARLES V. MOORE</u> ADDRESS <u>DENTON</u> | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |
| | | | | | | DATE <u>MAY 20 1968</u> | | | | | |

03333

OFFICE OF THE ATTORNEY GENERAL

03333

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1914
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1913
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1914

WILLIAM V. MOORE, ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Thomas Calvin Jones | | | | | | 5 Month 5 Day 1968 Year | | 6:30 A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years lost birthday) | | IF UNDER 1 YEAR MONTHS OAYS | | |
| male | | white | | 9/26/1877 | | 90 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | USA | | | | Talbot Md. | | | | |
| 1d. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Tilghman | | | Journey's End | | | Minister | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Talbot | | Tilghman | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | "Journey's End" | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | | |
| Thomas Frank Jones | | | | | | Emma Dickerson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| no | | | 221-16-6066 | | Mrs. Thomas C. Jones, Tilghman, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction immediate atherosclerotic cardiovascular. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-4 1953, 19, to 5-5 1968, that (I) (we) last saw the deceased alive on 5-4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Maurice E. Neunam Jr MD | | | | | 22c. DATE SIGNED 5-7-68 | | 22d. REGISTRAR'S NAME (Type) | | | |
| 22e. ADDRESS Maurice E. Neunam Jr | | | | | 22f. ADDRESS St Michaels Med. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 5/7/1968 | | Tilghman | | Tilghman, Md. | | | | |
| 24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md. | | | | | 25a. REC'D BY REGISTRAR DATE MAY 9 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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1. *Chlorophyll a* (Chl *a*)

[Faint bleed-through from the reverse side of the page]

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My dear Mr. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|--------------------------|--|---|--|---------------------------------|---|--|
| <div style="display: flex; justify-content: space-between;"> 07601 CERTIFICATE OF DEATH 07605 </div> | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) FRANK C Kotmair | | | | | 2a. DATE OF DEATH Month 5 Day 22 Year 68 | | 2b. HOUR 10 MIN A | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 6, 1899 | | 6. AGE (In years lost birthday) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot Md. | | | |
| 10. CITY-OR TOWN OF DEATH Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Policeman-Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Law | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Delaware | | 13b. COUNTY Marydel | | 13c. CITY OR TOWN Marydel | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Lost Louis Kotmair | | | | | 15. MOTHER'S MAIDEN NAME First Middle Lost Rachel Creamer | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mr. Theodore Duvall 904 Courtney Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 723.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: -733X (b) Spontaneous fracture of ribs DUE TO, OR AS A CONSEQUENCE OF (c) Idiopathic osteoporosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple spontaneous compression fractures of spine | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-15 , 19 68 , to 5-22 , 19 68 , that (I) (we) last saw the deceased alive on 5-21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert W. Trever | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5-22-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 5 25 68 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross | | 23d. LOCATION (City or Town) (County) (State) Brooklyn, A. A. Co. Md. | | | |
| 24. FUNERAL DIRECTOR Mc Gully | | | | ADDRESS 130 E. Fort Ave | | 25a. REC'D BY REGISTRAR DATE MAY 24 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR M | | |
| Patricia | | | Lewis | | | 5 4 68 | | 5 55 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | |
| Female | | White | | May 3, 1968 | | YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Md. | | U.S. | | | | Talbot | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Easton | | | Easton Mem. Hosp. | | | None | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Dor. | | Cambridge | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 307 Muir St. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| | | | Gloria Lewis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT 307 Muir St. Gloria Lewis, Cambridge, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) immobility | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) pulmonary and cerebral hemorrhage | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 7605 4319 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | 5/13/68 5/4 68 | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/13/68, to 5/4 68, that (I) (we) last saw the deceased alive on 19__, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did/ did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE A. Mehrizi | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5/7/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Doctor Ali. Mehrizi | | | | | 22e. ADDRESS Easton, Maryland 21601 5/7/68 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | May 7, 1968 | | Cambridge Cemetery | | Cambridge, Md. | | | | |
| 24. FUNERAL DIRECTOR John Thomas Thomas Funeral Home Cambridge | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|---|--|---|--|
| 07603 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07607 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last <i>Jessie Virginia Marshall</i> | | | 2a. DATE OF DEATH Month Day Year <i>5 25 68</i> | | | 2b. HOUR <i>8:35</i> M | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>3/14/1900</i> | | 6. AGE (In years last birthday) <i>68</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i> | | 12a. USUAL OCCUPATION (Kind of work done during last week, if not working, even if retired.) <i>Housework</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Talbot</i> | | 13c. CITY OR TOWN <i>Easton</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER <i>129 N. Locust St.</i> | | 14. FATHER'S NAME First Middle Last <i>Theodore Jones</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Martha Blake</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>218-09-6303</i> | | 17. INFORMANT Address <i>Edward L. Marshall, Sr. Easton, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>395.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Calcific aortic stenosis</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>5 days</i> <i>many years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4211</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>63</i> , to <i>25 May</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>25 May</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Stephen P. Carney</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>5-27-68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i> | | M.D. | | 22e. ADDRESS <i>Easton, Maryland</i> | | 22f. CITY OR TOWN <i>21601</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>5/28/1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i> | |
| 24. FUNERAL DIRECTOR <i>E. NEWMAN & SON, Easton, Md.</i> | | 24a. REG'D BY REGISTRAR <i>M. C. Newman</i> | | 24b. DATE <i>MAY 29 1968</i> | | 24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

30330

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-68
30M REV. 1-68

| | | | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|---|--|--------------------------------|--|
| Item 8, film G401 6/16/68 | | | | | | | | | | | | |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| Items #6, 7a, b, 23a, b, c, d Film #G401 6/16/68 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last <i>Hattie L. McDANIEL</i> | | | | | | 2a. DATE OF DEATH Month Day Year <i>May 20 1968</i> | | | 2b. HOUR Min. <i>2:45 P.</i> | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Col</i> | | 5. DATE OF BIRTH <i>June 4 1906</i> | | | 6. AGE (In years last birthday) <i>61</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Easton, Talb. Co.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Domestic</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>maid</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i> | | | 13b. COUNTY <i>Talbot</i> | | 13c. CITY OR TOWN <i>Easton</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>105 Glenwood Ave</i> | | | |
| 14. FATHER'S NAME First Middle Last <i>Charles Price</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Louise Barum</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. <i>213-24-1552</i> | | | 17. INFORMANT Address <i>Perry McDANIEL Easton Md</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute PULMONARY EDEMA</i> <i>402X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSIVE CARDIAC DISEASE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>443X</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>LEFT VENTRICULAR FAILURE</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 HRS.</i> <i>YRS.</i> <i>4 YRS.</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <i>DIABETES MELLITUS + DUODENAL ULCER DISEASE</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>JULY 1, 1965</i> , to <i>20 MAY, 1968</i> , that (1) (we) last saw the deceased alive on <i>20 MAY 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Richard F. Tyson</i> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>5-21-68</i> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Richard F. Tyson, M.D.</i> | | | | | | 22e. ADDRESS <i>221 Glenwood Av. Easton, Md. 21601</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>5/23/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Ivytown Cem.</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Easton #1 Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <i>George H Washburn Easton Md</i> | | | | | | 25a. REC'D BY REGISTRAR DATE <i>MAY 27 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>James Judge</i> | | | | |

0035

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07605

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07609

| | | | | | | | | | | | |
|---|---------|------------------------------|--|--|------|---|------|--|--|--|----------|
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Chester Earnest Mercer | | | | | | Month Day Year | | | 5 31 19 68 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | Negro | Aug. 10, | 81 YRS. | MONTHS | DAYS | HOURS | MIN. | Month Day Year | | | AM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | |
| Maryland | | USA | | | | Talbot | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Easton | | | Memorial | | | Cook | | | None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | Queen Anne Centreville | | | 101 Johnstown Lane | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| John T. Mercer | | | Eliza Johns | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Centreville, Md. | | |
| No | | | 218 05 4343 | | | Beatrice Mercer | | | 101 Johnstown Lane | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Beta Hemolytic Strep Septicemia</u> | | | | | | | | | | 24 hrs. | |
| DUE TO, OR AS A CONSEQUENCE OF <u>abscess of elbow</u> | | | | | | | | | | 2 weeks | |
| (b) <u>Dehydration</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| <u>Bi-lateral gangrene of feet due to self-applied rubber bands</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | HOUR A.M. P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>C. Rodney Layton</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>6/3/68</u> | | | |
| EXAMINER'S NAME (Type) <u>Dr. C. Rodney Layton</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (State) | | | |
| Burial | | 6/3/68 | | Chesterfield | | Queen Centreville Anne Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Barbara L. Dashiell Easton, Maryland | | | | | | DATE JUN 5 1968 | | <u>Charles Judge</u> | | | |

1260

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|----------------------|---|--|---|---|
| 1. DECEASED-NAME (Type or Print) ROBERT HARRIS MITCHELL | | 2a. DATE KNOWN OF DEATH ESTIMATED 5 12 1968 | | 2b. HOUR 6:30 PM | |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH March 12, 1921 | 6. AGE (In years last birthday) 47 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (State or foreign country) Norfolk, Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> (SEPARATED) | |
| 10. CITY OR TOWN OF DEATH (DOA) Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Day Laborer | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Caroline | | 13c. CITY OR TOWN Federalsburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Edward Middle Mitchell Last Mitchell | | 15. MOTHER'S MAIDEN NAME First Lottie Middle Hawks Last Hawks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II | | 16b. SOCIAL SECURITY NO. 217-05-5788 | | 17. INFORMANT ADDRESS Delores M. Hill, Federalsburg, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible epidural hemorrhage and possible 818.1 DUE TO, OR AS A CONSEQUENCE OF Right temporal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. basilar skull fracture fracture bone (b) minutes DUE TO, OR AS A CONSEQUENCE OF Automobile accident (c) minutes | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 825.4 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year 5/12/68 HOUR A.M. 2:30 P.M. PM | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Thrown from car was passenger | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Federalsburg Md | | 21f. LOCATION Street or R.F.D. No. Route 315 east of Federalsburg Md City or Town Federalsburg County Md State Md | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> also x-ray confirmed | | | | | |
| ACTUAL SIGNATURE [Signature] M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 5/14/68 | |
| EXAMINER'S NAME (Type) Preston Maryland | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) Preston arlene Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 16, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery | |
| 24. FUNERAL DIRECTOR Frampton Funeral Home, Federalsburg Md. | | ADDRESS Federalsburg, Maryland | | 25a. REGD BY REGISTRAR MAY 16 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

37602

100-100000-100000

100-100000-100000

100-100000-100000

CERTIFICATE OF DEATH

07607

07611

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) <i>Leona Elizabeth Moore</i> | | | 2a. DATE OF DEATH 5 Month 16 Day 1968 Year | | | 2b. HOUR M | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>4/18/1914</i> | | 6. AGE (In years last birthday) <i>54</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>S.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Trappe (rural)</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>RFD #1</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Talbot</i> | | 13c. CITY OR TOWN <i>Trappe</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>RFD #1</i> | |
| 14. FATHER'S NAME First Middle Last <i>Perry H. Drazdy</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Carrie Lovett</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>248-36-3646</i> | | 17. INFORMANT Address <i>Paul E. Moore, Trappe, Maryland</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4129</i> IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>131</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>subtle</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>17 Feb</i> , 19 <i>66</i> , to <i>16 May</i> , 19 <i>68</i> , that (I) (we) lost the deceased on <i>April</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Thorston Harrison, M.D.</i> DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>20 May 68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i> | | | | 22e. ADDRESS <i>Easton, Maryland</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>Burial</i> | | 23b. DATE <i>5/19/1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Landing Neck</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>MAURICE E. NEUNAM & SON, Easton, Md.</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>MAY 21 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

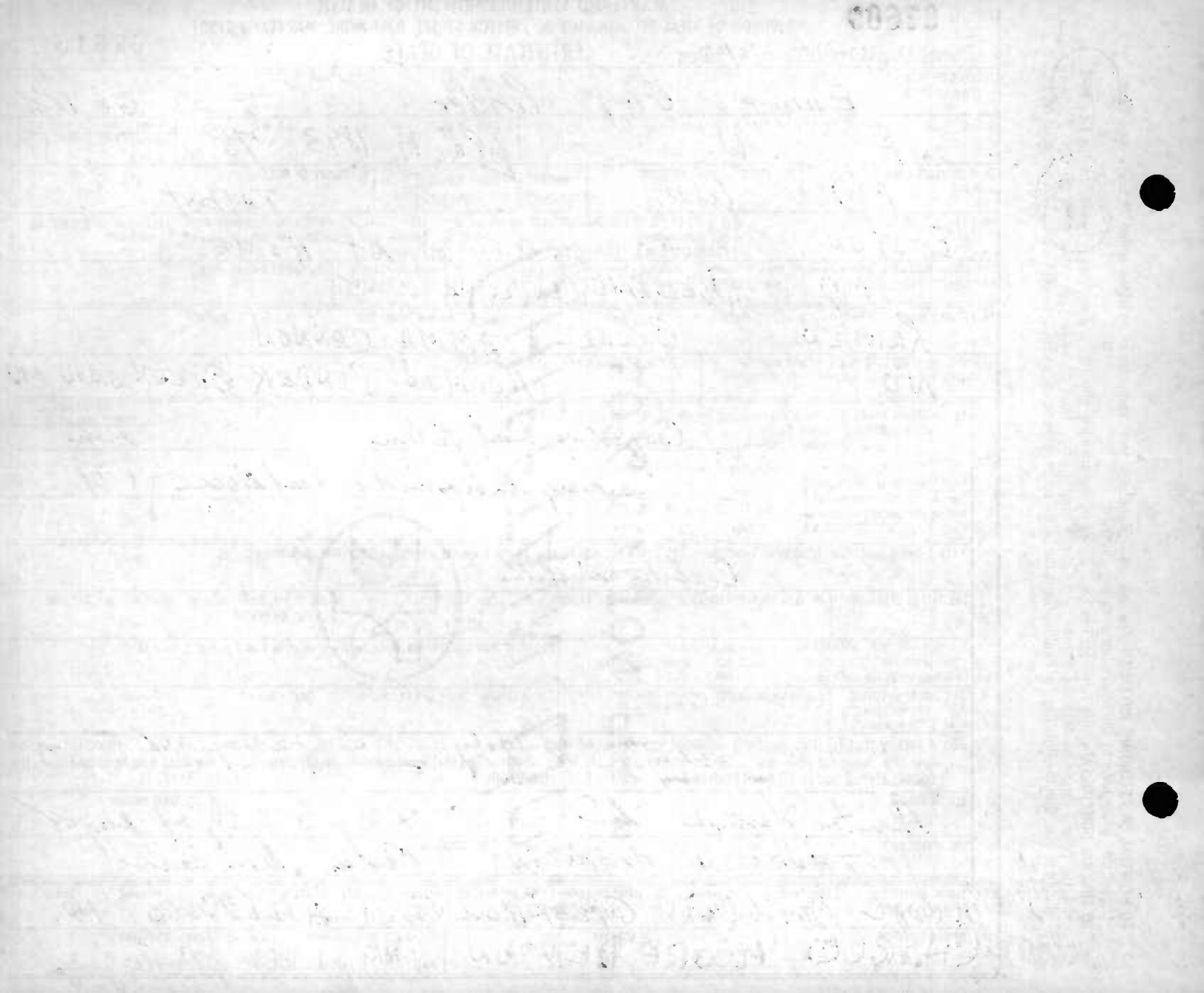
| | | | | |
|--|--------------------------|--|--|--|
| 1. DECEASED-NAME (Type or Print) <i>Andrew W. Postles, Jr.</i> | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>5</i> Day <i>17</i> Year <i>1968</i> | | 2b. HOUR <i>12:00</i> M |
| 3. SEX <i>M</i> | 4. RACE <i>Col.</i> | 5. DATE OF BIRTH <i>5-18-16</i> | 6. AGE (In years last birthday) <i>51</i> YRS. | 2c. DATE PRONOUNCED DEAD Month <i>5</i> Day <i>7</i> Year <i>1968</i> |
| 7a. BIRTHPLACE (State or foreign country) <i>DEL.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>TRUCK DRIVER</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i> | | 13b. COUNTY <i>CAROLINE</i> | | 13c. CITY OR TOWN <i>Denton</i> |
| 14. FATHER'S NAME First <i>Andrew W.</i> Middle <i>Postles</i> Last <i>SR.</i> | | 15. MOTHER'S MAIDEN NAME First <i>CLARA E.</i> Middle <i>Smith</i> Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> | | 16b. SOCIAL SECURITY NO. <i>WW II 222-07-1033</i> | | 17. INFORMANT ADDRESS <i>MRS. OLA P. TILDON HARRINGTON, DEL.</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Rib Fracture both sided with</i> <i>8120</i> DUE TO, OR AS A CONSEQUENCE OF <i>multiple internal injuries,</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>8164</i> (b) <i>including left hemothorax and right</i> DUE TO, OR AS A CONSEQUENCE OF <i>pneumothorax hemothorax</i> (c) <i>retroperitoneal hemorrhage rupture of both spleen</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>due auto accident as a driver Driver</i> | | | | |
| 19a. DATE OF OPERATION <i>none</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year <i>7:05 PM 5/13/68</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>thrown from car after having been hit</i> |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Denton Maryland street</i> | | 21f. LOCATION Street or R.F.D. No. <i>6th and Franklin</i> City or Town <i>Denton</i> County <i>Caroline</i> State <i>MD</i> |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE <i>Harold B. Flummer</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>5/13/68</i> |
| EXAMINER'S NAME (Type) <i>Harold B. Flummer</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | ADDRESS (Street, city, town, or county) <i>Preston Caroline</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 23b. DATE <i>5/11/68</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Williamsville</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Houston, Kent, DEL.</i> |
| 24. FUNERAL DIRECTOR <i>Tennis H. McKnight</i> | | ADDRESS <i>Harrington, Del.</i> | | 25a. REC'D BY REGISTRAR <i>May 15 1968</i> |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last <i>Eunice Gay Pinder</i> | | | | | 2a. DATE OF DEATH Month Day Year <i>5 23 68</i> | | | 2b. HOUR <i>10:15</i> M | |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH <i>APR. 19, 1893</i> | | 6. AGE (In years last birthday) <i>75</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospt. of Easton</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>AT HOME</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if in institution: Residence before admission) STATE <i>MD</i> | | 13b. COUNTY <i>QUEEN ANNE</i> | | 13c. CITY OR TOWN <i>CENTREVILLE</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last <i>REUBEN BACKLE</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>EMMA CANNON</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>NO</i> | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address <i>NORMAN PINDER QUEEN ANNE MD</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129 Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i> <i>(?)</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201 Diabetes mellitus</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>60</i> , to <i>23 May</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>23 May</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Thurston Harrison M.D.</i> DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>24 May 68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i> | | | | | 22e. ADDRESS <i>Easton, Maryland</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (State) | | 23b. DATE <i>May 26, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>GREEN MOUNT</i> | | 23d. LOCATION (City or Town) (County) (State) <i>HILLSBORO MD.</i> | | | |
| 24. FUNERAL DIRECTOR <i>CHARLES MOORE DENTON</i> ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE <i>MAY 31 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) CHARLES WINFIELD PITCHER | | | | | 2a. DATE OF DEATH Month May Day 9 Year 1968 | | 2b. HOUR 9:45 P.M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH October 29, 1896 | | 6. AGE (In years lost birthday) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot County Md. | | | |
| 1d. CITY OR TOWN OF DEATH St. Michaels | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ----- | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Asst Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY St. Hosp. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN St. Michaels | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Chew Avenue | |
| 14. FATHER'S NAME First Middle Last Charles S. Pitcher | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary A. Birs | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes | | (If yes give war or dates of service) WW I | | 16b. SOCIAL SECURITY NO. 138-30-3123A | | 17. INFORMANT Address Mrs. Holly C. Pitcher, St. Michaels, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 5 yr. (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF years. (c) 260x | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-30 , 19 66 , to 5-9 , 19 68 , that (I) (we) lost the the deceased alive on 9 May 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. Lane Wroth, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED 5-11-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) R. LANE WROTH, M. D. | | | | | 22e. ADDRESS St. Michaels, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 12, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park | | 23d. LOCATION (City or Town) (County) (State) Boston, Maryland | | | |
| 24. FUNERAL DIRECTOR Lawson E. Leonard, St. Michaels, Md. | | | | | 25a. REC'D BY REGISTRAR MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | |
|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME (Type or print) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| First Middle Last Cora Delia Roberts | | Month Day Year 5 6 68 | | M | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH Unknown | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (In years last birthday) 98 YRS. | |
| 10. CITY OR TOWN OF DEATH Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 803 Dover Road | | 9. COUNTY OF DEATH Talbot | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Talbot | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic | |
| 14. FATHER'S NAME First Middle Last Eldridge Roberts | | 15. MOTHER'S MAIDEN NAME First Middle Last Harriet Rideout | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. None | | 13c. CITY OR TOWN Clairborne | |
| 17. INFORMANT Address Blanche Caldwell, Clairborne, Maryland | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Rural community | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema with Kinney Failure 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Congestive Heart Failure 6 Wk DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio Vascular Disease 4221 20 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Right hemiplegia Partial | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13/68, 19__, to 5/6/68, 19__, that (I) (we) last saw the deceased alive on 5/6/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Dr. Harold B. Plummer | | | | 22c. DATE SIGNED 5/9/68 | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Harold B. Plummer | | | | 22e. ADDRESS Maple Ave., Preston, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY Easton | |
| 24. FUNERAL DIRECTOR Barbara L. Dashiell | | 23d. LOCATION (City or Town) (County) (State) Easton, Talbot, Maryland | | 25a. REC'D BY REGISTRAR MAY 13 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Louis Jacob Schmitt</i> | | | | | 2a. DATE OF DEATH 5 Month 10 Day Year 68 10 9 | | | 2b. HOUR 4:30 P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Sept. 14, 1919 | | 6. AGE (In years last birthday) 48 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot Md. | | | |
| 10. CITY OR TOWN OF DEATH Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Checker Latex Co. | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Caroline | | 13c. CITY OR TOWN Greensboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER None | |
| 14. FATHER'S NAME First Middle Last Frank Schmitt | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Marie Henschel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16b. SOCIAL SECURITY NO. WW 11 | | 17. INFORMANT Address Mabel Schmitt Greensboro, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lacteal-intestinal hemorrhage</i> <i>540.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Multiple gastric ulcers</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pertinent 20 to ruptured appendix</i> <i>550.1</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 day</i> <i>2 day</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>550.1</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>5-10</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>W.E. L. Jones</i> | | | | DEGREE ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, OR OTHER (Specify) Burial | | 23b. DATE 5-14-68 | | 23c. NAME OF CEMETERY OR CREMATORY Greensboro | | 23d. LOCATION (City or Town) (County) (State) Greensboro Caroline, Md. | | | |
| 24. FUNERAL DIRECTOR <i>John E. Bouleais</i> | | | | ADDRESS <i>Greensboro</i> | | 25a. REC'D BY REGISTRAR DATE MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV. 1968

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 07613 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07617 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Wilmer Louis Sparks</i> | | | 2a. DATE OF DEATH Month <i>5</i> Day <i>14</i> Year <i>68</i> | | | 2b. HOUR <i>1:13</i> M | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>June 10, 1901</i> | | 6. AGE (In years last birthday) <i>66</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>CARPENTER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>HOUSE</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i> | | 13b. COUNTY <i>QUEEN ANNES</i> | | 13c. CITY OR TOWN <i>CENTREVILLE</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <i>Charles</i> Middle <i>Major</i> Last <i>SPARKS</i> | | 15. MOTHER'S M maiden name First <i>Margaret</i> Middle <i>Cornelia</i> Last <i>WATERS</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>22-16-1400</i> | | 17. INFORMANT <i>Mrs. Edith Holden Sparks, CENTREVILLE, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>431.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Unknown</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5-13-68</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>331X</i> <i>None</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-14</i> , 19 <i>68</i> , to <i>5-14</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>5-14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Robert W. Trever, M.D.</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>5-15-68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever, M.D.</i> | | | | 22e. ADDRESS <i>Easton, Maryland</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>May 17, 1968</i> | | 23c. NAME OF CEMETERY, OR CREMATORY <i>Chesterfield Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>CENTREVILLE QUEEN ANNES, Md.</i> | |
| 24. FUNERAL DIRECTOR <i>James A. Barton Jr. Barton Bros, Centerville, Md.</i> | | 25a. REC'D BY REGISTRAR <i>21617</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | DATE <i>MAY 17 1968</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|-------------------|--------------------------------|---|--|
| 1. DECEASED-NAME (Type or print) | | | First NORMAN | Middle MAURICE | Last THOMAS | 2a. DATE OF DEATH Month Day Year May 18 1968 | | | 2b. HOUR 6 P M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Sept. 15, 1896 | | 6. AGE (In years last birthday) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Saint Michaels | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rio Vista Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired State Roads Employee | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C. | | 13b. COUNTY ---- | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 309 Livingston Terrace | | | | |
| 14. FATHER'S NAME First Middle Last John W. Thomas | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sallie Bevins | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. 217-09-7207 | | 17. INFORMANT Address Rolbert W. Thomas, Hill Crest Heights, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF <i>atherosclerotic coronary artery d.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>4201</i> (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>advanced senile changes.</i> | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>soon</i> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>5-8-67</i> , 19 <i>67</i> , to <i>5-18-68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-18-67</i> , 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Wm M. Reeder M.D.</i> | | 22c. DATE SIGNED <i>5-20-68</i> | | 22d. PHYSICIAN'S NAME (Type) <i>Wm M. Reeder</i> | | | | | | | | |
| 22e. ADDRESS <i>Saint Michaels Md.</i> | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REBURYAL (Specify) <i>Burial</i> | | 23b. DATE May 21, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Downing Church Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Oak Hall, Virginia | | | | | |
| 24. FUNERAL DIRECTOR <i>J. J. Frampton</i> | | 25a. REC'D BY REGISTRAR J. J. Frampton and Son, Federalburg, Maryland | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | DATE MAY 24 1968 | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Carrie E. Thompson | | | | | 2a. DATE OF DEATH Month 5 Day 3 Year 68 | | | 2b. HOUR M 6 | | | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH August 5, 1881 | | | 6. AGE (In years last birthday) 86 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Talbot Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Easton Memorial | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Private Family | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN Easton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 22 S. Aurora St. | | | |
| 14. FATHER'S NAME First Middle Last Perry Bantum | | | 15. MOTHER'S MAIDEN NAME First Middle Last Charlotta Smith | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | | | | |
| 16b. SOCIAL SECURITY NO. 180 18 2577 | | | 17. INFORMANT Address Easton, Md. A Joseph C. Bantum 22 S. Aurora St. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 402X DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure (b) Cerebral Apoplexy DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension 443X PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days yrs days | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) Richard F. Tyson attended the deceased from 5/2 , 19 68 , to 5/3 , 19 68 , that (I) did saw the deceased alive on 5/3 , 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Richard F. Tyson | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5-6-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Richard F. Tyson | | | | | 22e. ADDRESS 221 Glenwood Ave., Easton, Md. 21601 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/7/68 | | 23c. NAME OF CEMETERY OR CREMATORY Richards Memorial | | | 23d. LOCATION (City or Town) (County) (State) Easton Talbot Md. | | | | | |
| 24. FUNERAL DIRECTOR Barbara L. Dashiell | | | | | ADDRESS 426 Dover St. Easton | | 25a. REC'D BY REGISTRAR MAY 9 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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STATE OF NEW YORK

IN SENATE

January 1, 1961

REPORT

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COMMISSIONERS OF THE

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REPORT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and return them to the funeral director. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
30M REV. 1-68

07616

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07620

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) MARY Elizabeth White | | | 2a. DATE OF DEATH 5 Month 25 Day 68 Year 45 Min | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH 3-16-23 | |
| 7a. BIRTHPLACE (State or foreign country) CHARLESTON, S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH EASTON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital | | 9. COUNTY OF DEATH TALBOT | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY TALBOT | | 13c. CITY OR TOWN EASTON | |
| 14. FATHER'S NAME THOMAS | | 15. MOTHER'S MAIDEN NAME UNKNOWN | | 12b. KIND OF BUSINESS OR INDUSTRY NONE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 215-36-1617 | | 17. INFORMANT Waverly White, Harrison Rd Jarboe, Easton Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Portal Cirrhosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William E. Latimer | | | | 22c. DATE SIGNED 25 May '68 | |
| 22d. PHYSICIAN'S NAME (Type) William E. Latimer | | | | 22e. ADDRESS Easton Memorial Hosp. Easton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 5-28-68 | | 23c. NAME OF CEMETERY OR CREMATORY RICHARDS MEMORIAL | |
| 24. FUNERAL DIRECTOR J. B. Washell | | 23d. LOCATION (City or Town) (County) (State) EASTON TALBOT Md. | | 23e. ADDRESS 7426 DOVER ST. EASTON | |
| 24a. REC'D BY REGISTRAR J. Charles Judge | | 24b. REGISTRAR'S SIGNATURE J. Charles Judge | | 24c. DATE MAY 28 1968 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Copie Erwin Wilson | | | 2a. DATE OF DEATH Month 5 Day 10 Year 1968 | | | 2b. HOUR 1 P M | |
| 3. SEX Male | | 4. RACE Colored | | 5. DATE OF BIRTH July 2, 1893 | | 6. AGE (In years last birthday) 74 YRS. | |
| 7a. BIRTHPLACE (State or foreign) Hartington, Tenn. | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot Md. | |
| 10. CITY OR TOWN OF DEATH Easton, Maryland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to STATE) Maryland | | 13b. CITY OR TOWN Caroline | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Route # 1, Ridgely, Md | |
| 14. FATHER'S NAME First Samuel Middle Wilson Last Wilson | | 15. MOTHER'S MAIDEN NAME First Adeline Middle Blodsee Last Blodsee | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) No (If not give war or dates of service) | | 16b. SOCIAL SECURITY NO. 218-20-8782 | | 17. INFORMANT Memorial Hospital, Easton, Maryland Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 am , 19 68 , to 10 am , 19 68 , that (I) (we) last saw the deceased alive on 10 am , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Stephen P. Carney, M. D. | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 13 May 68 | |
| 22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M. D. | | 22e. ADDRESS Easton, Maryland | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) Burial | | 23b. DATE 5-13-1968 | | 23c. NAME OF CEMETERY OR CREMATORY New Hope Bapt. Church Cem | | 23d. LOCATION (City or Town) (County) (State) Hillsboro, Caroline, Maryland | |
| 24. FUNERAL DIRECTOR C.W. HILL, Denton, Md | | ADDRESS 413 Gay Street Denton, Md. | | 25a. REC'D BY REGISTRAR DATE MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Rites, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|-----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last James Henry Wilson | | | | | | 2a. DATE OF DEATH Month Day Year 5 4 68 | | | 2b. HOUR 7:55 A M | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH OCT 23-1918 | | 6. AGE (In years last birthday) 49 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Talbot Md. | | | | | |
| 10. CITY OR TOWN OF DEATH EASTON | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTON mem | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) labors | | 12b. KIND OF BUSINESS OR INDUSTRY farm | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN EASTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Route # EASTON MD | |
| 14. FATHER'S NAME First Middle Last Merton Wilson | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Hattie Hazelton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16b. SOCIAL SECURITY NO. 214-32-2302 | | 17. INFORMANT Address Mrs Bessie Brooks | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic invalidism due to old hemiparesis (stroke) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-3 , 19 68 , to 5-4 , 19 68 , that (I) (we) last saw the deceased alive on 5-4 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert W. Trever | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5-4-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 9, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ivey Town Cem. | | | | 23d. LOCATION (City or Town) (County) (State) APR. Easton TA. MD | | | |
| 24. FUNERAL DIRECTOR George H. Darrell Easton MD | | | | | | 25a. REC'D BY REGISTRAR DATE MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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DEPARTMENT OF AGRICULTURE

UNITED STATES GOVERNMENT

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